

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155307		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2011	
NAME OF PROVIDER OR SUPPLIER  TOWNE CENTRE HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410			
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Dates of survey: June 20, 21, 22, 23, 24, and 27, 2011</p> <p>Facility number: 000204 Provider number: 155307 Aim number: 100284910</p> <p>Survey team: Lara Richards, R.N., T.C. Heather Tuttle, R.N. Kathleen (Kitty) Vargas, R.N. Janelyn Kulik, R.N. (6/22-6/24 &amp; 6/27/11)</p> <p>Census bed type: SNF/NF: 88 Total: 88</p> <p>Census payor type: Medicare: 17 Medicaid: 56 Other: 15 Total: 88</p> <p>Stage 2 sample: 41</p> <p>These deficiencies also reflect State Findings cited in accordance with 410 IAC 16.2.</p>			F0000	<p>Preparation and implementation of this plan of correction does not constitute admission or agreement by Towne Centre Health Care of the truth of the facts, findings, or other statements as alleged by the preparer of the survey/inspection dated 6-27-11. Towne Centre Health Care specifically reserves the rights to move to strike or exclude this document as evidence in any civil, administrative, and criminal action not related directly to the licensing and/or certification of this facility or provider.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0166 SS=D	<p>Quality review 7/05/11 by Suzanne Williams, RN</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interviews, the facility failed to ensure all complaints and grievances were thoroughly investigated related to a report of a missing watch for 1 of 2 residents reviewed for personal property of the 2 residents who met the criteria for personal property. (Resident #13)</p> <p>Findings include:</p> <p>On 06/20/2011 at 2:11 p.m., during interview, Resident #13 indicated her watch had been missing for about 3 months, and she had no idea what happened to her watch. The resident further indicated that she had reported it missing.</p> <p>Review of the complaint and grievance form dated 5/12/11, indicated the resident reported a watch missing as well as a new outfit. The new outfit was found and was given to laundry to label. The resolution indicated, "Resident does have dementia and it was possible watch was never present but we will</p>		F0166	<p>F166 1) #13 resident clothing was found and returned. The watch had been taken by the son to a jeweler to have the battery replaced. Resident acknowledges that her son still has her watch as of 7-13-2011 and she stated to the social service designee that she "is not concerned about it". 2) Any residents that have missing items will be referred to social service and social service will follow the grievance procedure. 3) Social Service department will be in-serviced on the grievance procedure. Social Service designee will review grievances as soon as possible but within 5 days of grievance for completion. In-service will be provided by CMP consultant to the Social Service staff by 7-20-11. 4) Administrator or designee will review all grievances weekly to assure grievances have been satisfied. Social Services will report monthly to the QA committee the results of the weekly reviews until 3 months of compliance is met at 95%, then the review of grievances will occur monthly, and reported monthly to the QA Committee ongoing.5) Completion date 7-27-11</p>		07/27/2011	

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	<p>continue to search for watch." The watch had not been found or replaced at that time. The grievance form was signed by the Administrator as being completed and investigated on 5/19/11.</p> <p>The record for Resident #13 was reviewed on 6/23/11 at 9:25 a.m. The quarterly Minimum Data Set (MDS) assessment dated 5/27/11, indicated the resident understood and understands and the resident also had a BIMS (Brief Interview for Mental Status) score of 13.</p> <p>Review of the resident's personal inventory sheet, indicated the resident's watch was not listed.</p> <p>Review of the current 9/10 Grievance/Concern Policy and Procedure provided by the Administrator, indicated an investigation will be completed by the appropriate staff member and follow-up will be documented on the form within five working days.</p> <p>Interview with the Social Service Director on 6/23/11 at 9:55 a.m., indicated the procedure for filing a complaint was to complete the complaint and grievance form and give it to the appropriate department</p>						

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F0247 SS=E	and the Administrator.  Interview with the Administrator on 6/23/11 at 9:57 a.m., indicated the facility's policy was to typically not replace any items such as money or articles that were reported lost or stolen. She indicated that she has however done that in the past. She indicated the normal procedure was to investigate whatever article was missing or reported stolen. The Administrator indicated that she did not investigate the lost watch, she indicated she just wrote the resident has diagnoses of dementia and had thought the watch may never have even been at the facility. She indicated the missing watch was overlooked due to the fact they had found her missing clothes.						
	<b>3.1-7(a)(2)</b>  A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interviews, the facility failed to ensure the residents were given notice of a new roommate for 3 of 4 residents reviewed for Admission, Transfer, and Discharge of the 4 residents who met the criteria for Admission, Transfer, and Discharge in the sample of 41.		F0247	F – 247 1) Current residents have all met their roommates. 2) All residents have the potential to be affected. Social Services will notify all affected residents prior to room change or admission. Residents affected by weekend changes will be notified by social services or other designee. 3) Social services will be in-serviced		07/27/2011	

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	<p>(Residents #10, #13, and #116)</p> <p>Findings include:</p> <p>1. Interview with Resident #10 on 6/21/11 at 10:46 a.m., indicated the resident was not given notice before getting a new roommate.</p> <p>The record for Resident #10 was reviewed on 6/27/11 at 8:47 a.m. There was no documentation indicating the resident had been notified of getting a new roommate.</p> <p>Interview with Social Service employee #1 on 6/27/11 at 9:30 a.m., indicated the resident received a new roommate on 4/15/11. At that time, the Social Service Employee indicated there was no documentation in the resident's record indicating she was given notice of the new roommate.</p> <p>2. Interview with Resident #13 on 6/20/11 at 2:20 p.m., indicated she was not given notice of a new roommate.</p> <p>The record for Resident #13 was reviewed on 6/27/11 at 8:51 a.m. Review of Social Service Progress notes, indicated an intractability transfer notice dated 8/12/10. The</p>				<p>on the need to notify all affected residents when they are getting a new roommate or room changes, and to document the notification in the medical record. Social Service employees will be in-serviced on or by 7-20-2011 by CMP consultant. 4) Social Service will notify residents on Fridays of any planned weekend admissions. Residents receiving unplanned new roommates will be notified by Social Service Designee or Weekend Manager prior to admission. All in-house transfers will be notified prior to being moved and new Roommates will be notified prior to receiving new roommate per Social Service or Designee. Transfer notification will be documented in Social Service Progress notes. In-house transfers will be monitored for notification daily M-F by Administrator or designee and any missed notifications will be performed immediately. Administrator will report monthly to the QA Committee results until 90% compliance is met for 3 consecutive months then results will be reviewed quarterly. 5) Completion date 7-27-11</p>		

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	<p>resident wanted a different room. The resident received a roommate on 9/1/10, and there was no documentation she was given notice of the new roommate.</p> <p>Interview with Social Service employee #1 on 6/27/11 at 9:30 a.m., indicated the resident did not receive notice prior to getting a new roommate on 9/1/10.</p> <p>3. Interview with Resident #116 on 6/21/11 at 1:25 p.m., indicated she was not given notice prior to getting new roommates in the last nine months.</p> <p>The record for Resident #116 was reviewed on 6/27/11 at 10:07 a.m. There was no documentation indicating the resident had been notified of receiving new roommates.</p> <p>Interview with Social Service employee #1 on 6/27/11 at 9:40 a.m., indicated Resident #116 received a new roommate on 5/27/11. This was a new admission from the hospital. That resident was discharged from the facility on 6/7/11. Resident #116 then received another new roommate on 6/9/11. Both times the Social Service employee indicated there was no documentation indicating the</p>						

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F0248 SS=D	<p>resident was given notice prior to receiving a new roommate.</p> <p><b>3.1-3(v)(2)</b></p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure residents who were bedridden received ongoing sensory stimulation activities for 1 of 1 bed bound residents reviewed for activities in the sample of 41. (Resident #61)</p> <p>Findings include:</p> <p>On 6/20/11 at 10:00 a.m., 12:45 p.m., and 3:16 p.m., Resident #61 was observed in bed. There was no radio or TV on in her room.</p> <p>On 6/21/11 at 8:40 a.m., the resident was in bed, there was no TV or radio on.</p> <p>On 6/22/11 at 8:51 a.m., 10:00 a.m., and 2:12 p.m., the resident was in bed. There was no radio or television on in her room.</p> <p>On 6/23/11 at 8:56 a.m., and 11:17</p>			F0248	<p>F – 248 1) The Care Plan and the C.N.A. Assignment Sheet have been updated for resident #61. 2) Bed Bound residents will be identified per clinical assessment. Sensory stimulation will be provided for periods throughout the day per care plan to any bed bound residents. 3) The initial activity assessment will identify any other residents that require sensory stimulation. Activity and Nursing staff have been inserviced on sensory stimulation. 4) Activity Director will monitor activity assistants weekly to assure sensory stimulation is occurring. Administrator or designee will monitor the activity One to One logs weekly to assure sensory stimulation is occurring. Results will be reported to the QA Committee monthly until 95% compliance is met for 3 months consecutively then quarterly. 5) completion date: 7-27-2011.</p>		07/27/2011

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	<p>a.m., the resident was in bed. Her eyes were open at those times. There was no radio or television on in her room.</p> <p>On 6/24/11 at 8:43 a.m., 10:00 a.m., and 11:16 a.m., the resident was in bed with her eyes open. There was no radio or TV on in the room.</p> <p>The record for Resident #61 was reviewed on 6/22/11 at 2:00 p.m. The resident's diagnoses included, but were not limited to, stroke and semi comatose/vegetative state.</p> <p>Review of Physician orders on the current 6/11 recap, indicated the resident was receiving Hospice services.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated 4/11/11, indicated the resident was rarely understood, rarely understands, and was severely impaired for decision making. The resident was totally dependent on staff for all ADLs. The staff assessment of daily and activity preferences, indicated the resident preferred listening to music, participated in religious events, and received bed baths.</p>						

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	<p>Review of the current plan of care updated on 6/24/11, indicated the resident needed sensory stimulation, with the staff approach to put the television on in her room. The care plan indicated the resident enjoyed music, with the staff approach to rotate the television and the music in her room.</p> <p>Review of the Activity Progress Notes dated 5/7-5/12/11, indicated the resident received sensory stimulation in her room. The activity department provided music and television. The television was on in her room more for sensory stimulation.</p> <p>Interview with the Activity Director on 6/24/11 at 10:43 a.m., indicated she has educated her staff as well as the CNAs to put the television and radio on in the resident's room.</p> <p>Interview with the hospice CNA who comes everyday, on 6/24/11 at 8:20 a.m., indicated the TV and/or the radio was on in the resident's room once in awhile. She indicated that she normally does not turn on the TV or radio while she was there.</p> <p><b>3.1-33(a)</b></p>						

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F0253 SS=E	<p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure the residents' environment remained clean, comfortable and functional, related to a soiled wheelchair (Room #1129), a missing light bulb in the bathroom (Room #1116), chipped wall paint, marred and scuffed walls and torn wallpaper for 2 of 2 floors (Rooms #1118, #1120, #1219, and #1223), a soiled tube feeding pole (Room #1219), and missing and cracked chair railing (Room #1200 and #1224), and an uncovered plastic container used to collect urine on the floor (Room #1115). This had the potential to affect 9 of 35 residents who resided on the first floor and 7 of 53 residents who resided on the second floor.</p> <p>Findings include:</p> <p>During the Environmental tour on 6/24/11 at 1:35 p.m., the following was observed on the first floor:</p> <p>a. The wheelchair was covered with a light brown substance on the left side in room 1129. Two residents resided in this room.</p>			F0253	<p>F – 253 Environmental 1) First floor: a. Wheelchair in room 1129 has been cleaned. b. light bulb in room 1116 has been replaced. c. area of chipped paint in room 1118 had been repaired. d. areas noted have been repainted in room 1120. e. plastic container in room 1115 was removed immediately at time of survey. Second floor: a. chair railing in room 1200 has been replaced. b. marred wall repaired and tube feeding pole cleaned in room 1219. c. marred wallpaper in room 1223 has been repaired. d. chair railing replaced in 1224. 2) Environmental review of all rooms on both floors has been completed to identify other areas in need of repair, painting or cleaning. 3) Maintenance staff to perform routine maintenance rounds weekly to change light bulbs, identify any marred walls or chipped paint, chair rails in need of repair or replacement. Any identified areas in need of repair from the weekly tour will be repaired immediately or within the following 7 days. Hall Monitor rounds will identify any items of nursing equipment and/or supplies which are soiled will be cleaned or removed from the area immediately until cleaned, repaired or replaced. Any other items in need of paint, repair or replacement will be reported on</p>		07/27/2011

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	<p>b. There was a light bulb missing from the bathroom light fixture in room 1116. Two residents resided in this room.</p> <p>c. The paint was chipped by the closet in room 1118. Two residents resided in this room.</p> <p>d. There were two colors of paint on the wall and chipped paint by the bathroom door in room 1120. One resident resided in this room.</p> <p>When interviewed at this time, the Maintenance Manager, Housekeeping Manager and Administrator, indicated the light bulb was missing, the wall paint was chipped and there were two colors of paint on the wall which was being repaired, and the wheelchair was soiled.</p> <p>e. On 6/20/11 at 3:36 p.m., a white plastic container used to collect urine, which was not covered, was observed on the floor in the shower in room 1115.</p> <p>On 6/24/11 at 1:35 p.m., during the environmental tour, the white plastic container used to collect urine, which was not covered, was observed on the floor in the shower stall in room</p>				<p>the maintenance log for review by the Maintenance staff to address daily and repairs to be completed immediately or within 7 days. 4) Administrator or designee to perform Environmental Rounds at least 5 days per week. Items on maintenance log will be reviewed for proper completion and timeliness of completion. Any non-compliance of completion or timeliness will be forwarded to the Executive Director for further interventions. Unit Managers to perform Environmental rounds 5 days per week and to review daily cleaning schedules of nursing equipment. DON to perform environmental rounds at least weekly to monitor Unit Manager compliance with performing their rounds. Administrator will report results of rounds to the monthly QA Committee until 90% compliance is met for 3 consecutive months, then Administrator will report results quarterly.5) Completion date 7-27-11</p>		

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	<p>1115. Two residents resided in this room.</p> <p>Interview with the Administrator on 6/24/11 at the time of the environmental tour, indicated the plastic container should not have been uncovered, and she informed a staff member to take care of the container.</p> <p>2. During the Environmental tour on 6/24/11 at 1:55 p.m., the following was observed on the second floor:</p> <p>a. A piece of the chair railing was broken and missing from the wall next to the bathroom in room 1200. Two residents resided in this room.</p> <p>b. The wall was marred under the window and the tube feeding pole was covered in a dried tan substance in room 1219. Two residents resided in this room.</p> <p>c. The wallpaper was marred behind the bed by the window in room 1223. Two residents resided in this room.</p> <p>d. The chair railing was missing by the closet in room 1224. One resident resided in this room.</p> <p>When interviewed at this time, the</p>						

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F0278 SS=D	<p>Maintenance Manager, Housekeeping Manager, and Administrator, indicated the chair rail was broken and missing, the walls and the wallpaper was marred, and the tube feeding pole was soiled.</p> <p>3.1-19(f)</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on observation, record review and interview, the facility failed to</p>			F0278	<p>F – 278 Assessments 1) Resident #88 was seen by the dentist on 7-5-11. Resident refused to have</p>		07/27/2011

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	<p>ensure an accurate dental/oral assessment was completed for 1 of 3 residents reviewed for dental status and issues for 9 residents that met the criteria for dental status in a sample of 41. (Resident #88)</p> <p>Findings include:</p> <p>On 6/20/11 at 1:54 p.m., Resident #88 was observed with missing teeth and a broken tooth on the top. On 6/22/11 at 9:01 a.m., the resident was observed in the dining room eating breakfast. He was observed with teeth missing on the bottom.</p> <p>Review of the Quarterly Minimum Data Set Assessment dated 4/8/11, indicated oral/dental status, had an "X" in the box next to none of the above were present. The boxes not marked included, but was not limited to, obvious or likely cavity or broken teeth, inflamed or bleeding gums or loose natural teeth, and unable to examine.</p> <p>A dentist note dated 11/2/10, indicated no exam was performed due to the resident being combative.</p> <p>A dentist note dated 4/12/11, indicated the resident had a broken #28 tooth. The broken tooth was to</p>				<p>his tooth repaired. 2) All residents have the potential to be affected. Residents see Prime Source for dental care unless otherwise requested by resident. 3)Dental assessments are completed quarterly and may vary according to Resident's dentation (such as chipped teeth, cavities, etc.) at the time of assessment. Licensed Nurses will be in-serviced by 7-26-11 on completing dental assessments. Nurses will report dental needs to Social Services who will schedule appointments with the Dentist. 4) Prime Source and/or personal Dental reports will be reviewed by the Unit Managers for proper provision of services as requested and results of their reviews will be presented to the monthly QA ongoing. 5) completion date: 7-27-2011.</p>		

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F0282 SS=D	<p>be watched at this time.</p> <p>A nursing note dated 4/12/11 at 4:00 p.m., indicated dentist examined teeth. There were no new orders.</p> <p>Interview with MDS nurse #1 on 6/24/11 at 9:13 a.m., indicated she did do the dental/oral assessment on resident #88. She did not recall seeing any broken teeth. She further indicated she was not sure if she had visualized all of the resident's teeth due to the resident could be combative. She then indicated she was not sure if she had seen all of the resident's teeth, she would have been able to see the teeth in the front but not the teeth in the back of his mouth.</p> <p>3.1-31(g)</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interviews, the facility failed to ensure the resident's plan of care was followed related to activities for 1 of 1 bedridden residents reviewed for activities. The facility also failed to ensure Physician orders were followed related to range of motion and splint application and the</p>		F0282	<p>F – 282 Care Plans 1) Resident #13 hand splint was applied after PROM was completed. Resident #61 – see F248. Stimulation has been provided per new care plan. Resident #73 Geri sleeves were applied. 2) All residents have the potential to be affected. Splints will be applied by Restorative Nursing per orders and care plan. Initial Activity Assessment will</p>		07/27/2011	

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	<p>application of geri sleeves for 1 of 3 residents reviewed for contractures and for 1 of 3 residents reviewed for skin conditions in the sample of 41. (Residents #13, #61 and #73)</p> <p>Findings include:</p> <p>1. On 6/23/11 at 8:55 a.m., Resident #13 was observed up in the wheelchair in her room. There was no splint on her right hand. At 2:30 p.m., the resident was in her room with her eyes closed, sitting in a wheelchair. There was no splint on her right hand.</p> <p>Interview with the resident on 6/23/11 at 2:50 p.m., indicated the CNA had not put her splint on her hand all day as of that time.</p> <p>On 6/24/11 from 8:15-9:00 a.m., the resident was up in her wheelchair in the dining room. She was not wearing her right hand splint.</p> <p>Interview at 9:00 a.m., with the resident, indicated the CNA had not placed it on her hand after she was done helping her with morning care.</p> <p>On 6/24/11 at 12:45 p.m., the resident was up in a wheelchair in the main dining room eating lunch. There was</p>				<p>identify any resident requiring sensory stimulation and will be care planned accordingly. Any Resident with orders for geri sleeves or long sleeves will be so attired. 3) Hand splints are now being applied per Restorative Nursing (who are present in facility 7 days per week) and Nurses will be checking to assure placement. The initial Activity Assessment will identify any other residents that require sensory stimulation. Geri sleeves or long sleeves will be applied per C.N.A. and nurses will check every shift to assure residents have the sleeves on as ordered. 4) Unit Managers will monitor 3 times per week for presence of splints, sensory stimulation and sleeves as ordered and care planned. Unit Manager will report findings monthly to the QA committee until compliance is achieved at 95% for 3 consecutive months then quarterly. 5) completion date: 7-27-2011.</p>		

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	<p>no splint in place to her right hand. The splint was observed in her room on the bed side table.</p> <p>On 6/24/11 at 1:40 p.m., the resident was observed in her room. There was no splint to her right hand. At that time, CNA #3 was asked to see her CNA assignment sheet. The care for Resident #13 indicated she was to wear a right hand splint at all times. The CNA then indicated the resident was up when she got there, and she did not put her splint on at all during the day. She further indicated she would have to ask the nurse if the resident was to have the splint on because she did not know for sure as she normally worked downstairs on another unit. LPN #4 indicated at that time, the resident was to have the splint on her right hand. The CNA then indicated she would put the splint on the resident's right hand. The CNA walked into the resident's room and placed clean gloves to both her hands, and applied the splint to the right hand with the resident's help. The CNA did not perform any passive range of motion to her right hand before applying the splint. Interview with the CNA at that time, indicated she was unaware the resident was to have passive range of motion to her hand.</p>						

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	<p>The record for Resident #13 was reviewed on 6/23/11 at 9:25 a.m. The resident had the diagnoses of right knee replacement, arthritis, and stroke.</p> <p>Review of Physician Orders dated 9/14/10, indicated right hand resting hand splint for positioning on always except during sleep. Another Physician order dated 10/27/10, indicated Restorative nursing remove right hand splint and provide passive range of motion to right hand up to 10 reps using gentle movement then reapply splint.</p> <p>Interview with the Restorative Nurse on 6/23/11 at 4:00 p.m., indicated the resident was not on the restorative program for the splint application and that it was up to the CNAs on the floor to put her splint on and do the range of motion.</p> <p>Further interview with the Restorative Nurse on 6/24/11 at 1:53 p.m., indicated the CNAs were to perform range of motion and apply splints on those residents who wear the splint all day.</p> <p>2. On 6/20/11 at 10:00 a.m., 12:45 p.m., and 3:16 p.m., Resident #61</p>						

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	<p>was observed in bed. There was no radio or TV on in her room.</p> <p>On 6/21/11 at 8:40 a.m., the resident was in bed, there was no TV or radio on.</p> <p>On 6/22/11 at 8:51 a.m., 10:00 a.m., and 2:12 p.m., the resident was in bed. There was no radio or television on in the room.</p> <p>On 6/23/11 at 8:56 a.m., and 11:17 a.m., the resident was in bed. Her eyes were open at those times. There was no radio or television on in her room.</p> <p>On 6/24/11 at 8:43 a.m., 10:00 a.m., and 11:16 a.m., the resident was in bed with her eyes open. There was no radio or TV on in the room.</p> <p>The record for Resident #61 was reviewed on 6/22/11 at 2:00 p.m. The resident's diagnoses included, but were not limited to, stroke and semi comatose/vegetative state.</p> <p>Review of Physician orders on the current 6/11 recap, indicated the resident was receiving Hospice services.</p> <p>Review of the current plan of care</p>						

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	<p>updated on 6/24/11, indicated the resident needed sensory stimulation with the staff approaches to put the television on in her room. The resident enjoyed music, with the staff approaches to rotate the television and the music in her room.</p> <p>Interview with the Activity Director on 6/24/11 at 10:43 a.m., indicated she has educated her staff as well as the CNAs to put the television and radio on in the resident's room.</p> <p>Interview with the hospice CNA who comes everyday, on 6/24/11 at 8:20 a.m., indicated the TV and/or the radio was on in the resident's room once in awhile. She indicated that she normally does not turn on the TV or radio while she was there.</p> <p>3. On 6/22/11 at 8:59 a.m., Resident #73 was observed in the dining room being fed. She was observed sitting in her wheelchair with a dressing to her right arm dated 6/21/11. She was wearing short sleeves and no geri-sleeves.</p> <p>On 6/22/11 at 1:13 p.m., the resident was observed sitting in the hallway by the nurses' station in her wheelchair. There was a dressing to her right forearm dated 6/22/11. She was wearing short sleeves and no</p>						

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	<p>geri-sleeves.</p> <p>On 6/22/11 at 3:30 p.m., the resident was observed laying in bed on her left side. She was reaching for the wall with her right arm. There was a dressing on her right forearm dated 6/22/11. She was wearing short sleeves and no geri-sleeves.</p> <p>On 6/23/11 at 7:57 a.m., the resident was observed in the dining room with a dressing on her right arm dated 6/22/11. The resident was wearing short sleeves and no geri-sleeves.</p> <p>The resident's record was reviewed on 6/22/11 at 9:10 a.m. Her diagnoses included, but were not limited to, neuropathy, anxiety, depressive disorder, left and right knee replacements, gastric esophageal reflux disease, history of urinary tract infections, hyperlipidemia, peripheral neuropathy, peripheral arterial disease, congestive heart failure, right hip replacement, coronary artery disease, legally blind, left humeral fracture, and dementia.</p> <p>Review of the Physician order statement for June, 2011, indicated on 5/2/11 the resident was to have a geri-sleeve or long sleeve to the right</p>						

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	<p>upper extremity.</p> <p>A physician order dated 4/24/11 at 10:00 a.m., indicated "geri-sleeves or long sleeves as tolerated."</p> <p>A physician order dated 5/2/11 at 3:30 p.m., indicated the resident was to have geri-sleeves or long sleeves to the right upper extremity and to discontinue geri-sleeve to left upper extremity.</p> <p>A Nursing Progress note dated 3/28/11 at 8:30 a.m., indicated the resident had a 2 cm (centimeter) by 3 cm skin tear to her right lower extremity. A treatment was ordered by the physician.</p> <p>Review of a Bath &amp; Skin Report dated 4/1/11, indicated the resident had 8 bruises to her left arm and a scab on her left elbow.</p> <p>A nursing note dated 4/30/11 at 9:19 a.m., indicated while transferring the resident she received a skin tear greater than 0.5 cm to her upper back right arm and lower right elbow.</p> <p>A nursing note dated 6/15/11 at 12:00 p.m., indicated the resident was seen by staff scratching her right forearm. She sustained a 0.3 cm skin tear.</p>						

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	<p>A nursing note dated 6/17/11 at 2:00 p.m., indicated the resident was seen moving her right arm and she made contact with the table. She sustained a 0.3 cm skin tear to her right arm.</p> <p>A significant change Minimum Data Set Assessment dated 5/5/11, indicated the resident was at risk for pressure ulcers per formal assessment instrument/tool and clinical assessment. She received applications of ointments/medications and there were no other skin issues.</p> <p>Interview with CNA #2 on 6/23/11 at 6:28 a.m., indicated there was no special care issues in regards to Resident #73. She then pulled her resident care sheet out of her pocket to indicate she was carrying her care sheet.</p> <p>Review of the CNA care sheet that was provided by CNA #1 on 6/23/11 at 10:32 a.m., indicated the resident was to have on geri-sleeves.</p> <p>On 6/23/11 at 1:30 p.m., CNA #1 was observed pulling back the covers on the resident. The resident had on short sleeves and a dressing was observed on her right forearm. CNA #1 reviewed her care sheet and</p>						

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F0309 SS=D	<p>indicated the resident was to have on geri-sleeves. She then indicated she could not find the geri-sleeves this morning and that was why she did not have the geri-sleeves on at this time.</p> <p>Interview with the Director on Nursing on 6/24/11 at 2:20 p.m., indicated she was aware the resident had not had on her geri-sleeve or long sleeves for the past two days and she should have had on geri-sleeves or long sleeves.</p> <p>3.1-35(g)(2)</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to provide thorough assessments, interventions and ensure interventions were in place related to skin tears and bruises for 1 of 3 residents reviewed with skin conditions of the 6 residents that met the criteria for non pressure related skin conditions. (Resident #73)</p> <p>Findings include:</p>			F0309	<p>F – 309 1) Resident #73 will have geri-sleeve or long sleeves in place as ordered and/or care planned. 2) Any resident with order to have geri-sleeves and/or long sleeves will be so attired. 3) The order for long sleeves or geri-sleeves will be written on the TAR and nurses will document adherence to this order on each shift as appropriate. 4) The Unit Managers will monitor any/all residents with geri-sleeve/long sleeve order and/or care plan 3 days per week. Findings will be</p>		07/27/2011

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	<p>On 6/22/11 at 8:59 a.m., Resident #73 was observed in the dining room being fed. She was observed sitting in her wheelchair with a dressing to her right arm dated 6/21/11. She was wearing short sleeves and no geri-sleeves. At 1:13 p.m., the resident was observed sitting in the hallway by the nurses' station in her wheelchair. There was a dressing to her right forearm dated 6/22/11. She was wearing short sleeves and no geri-sleeves. At 3:30 p.m., the resident was observed lying in bed on her left side. She was reaching for the wall with her right arm. There was a dressing on her right forearm dated 6/22/11. She was wearing short sleeves and no geri-sleeves.</p> <p>On 6/23/11 at 7:57 a.m., the resident was observed in the dining room with a dressing on her right arm dated 6/22/11. The resident was wearing short sleeves and no geri-sleeves.</p> <p>The resident's record was reviewed on 6/22/11 at 9:10 a.m. Her diagnoses included, but were not limited to, neuropathy, anxiety, depressive disorder, left and right knee replacements, gastric esophageal reflux disease, history of urinary tract infections,</p>				<p>reported to the QA Committee until compliance is maintained at least 95% for 3 consecutive months then quarterly. 5) completion date: 7-27-2011.</p>		

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	<p>hyperlipidemia, peripheral neuropathy, peripheral arterial disease, congestive heart failure, right hip replacement, coronary artery disease, legally blind, left humeral fracture, and dementia.</p> <p>A significant change Minimum Data Set Assessment dated 5/5/11, indicated the resident was usually understood and usually understands. She had a BIMS (Brief Interview of Mental Status) score of 5 which indicated she was severely impaired cognitively. She was totally dependent requiring full staff assist with two plus person physical assist with transfers. She was at risk for pressure ulcers. She had the application of ointments and medications. There were no other skin issues.</p> <p>Review of the Physician order statement for June, 2011, indicated on 5/2/11 the resident was to have a geri-sleeve or long sleeve to the right upper extremity.</p> <p>A physician order dated 4/24/11 at 10:00 a.m., indicated "geri-sleeves or long sleeves as tolerated."</p> <p>A physician order dated 5/2/11 at 3:30 p.m., indicated the resident was to</p>						

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	<p>have geri-sleeves or long sleeves to the right upper extremity and to discontinue the geri-sleeve to the left upper extremity.</p> <p>A physician order dated 5/23/11 at 3:00 p.m., indicated apply triple antibiotic ointment to skin tear on right forearm times five days.</p> <p>A nursing progress note dated 3/28/11 at 8:30 a.m., indicated the resident had a 2 cm (centimeter) by 3 cm skin tear to her right lower extremity. A treatment was ordered by the physician.</p> <p>Review of a Bath &amp; Skin Report dated 4/1/11, indicated the resident had 8 bruises to her left arm and a scab on her left elbow. There were no measurements of any of the bruises.</p> <p>Review of the nursing progress notes from 4/1/11 through 4/4/11, indicated no documentation in regard to the bruising.</p> <p>A nursing progress note dated 4/30/11 at 9:19 a.m., indicated while transferring the resident she received a skin tear greater than 0.5 cm to her upper back right arm and lower right elbow.</p>						

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	<p>A nursing progress note dated 5/23/11 at 8:45 a.m., indicated the resident fell out of the wheelchair onto the floor in the dining room on her left side. The sling remained intact to her left arm. Her legs were drawn up in a fetal position. She was able to move her legs. The resident denied any pain or discomfort.</p> <p>Review of the nursing progress notes for 5/23/11 through 6/16/11, indicated no skin tear to the right forearm.</p> <p>A nursing progress note dated 6/15/11 at 12:00 p.m., indicated the resident was seen by staff scratching her right forearm. She sustained a 0.3 cm skin tear.</p> <p>A nursing progress note dated 6/17/11 at 2:00 p.m., indicated the resident was seen moving her right arm and she made contact with the table. She sustained a 0.3 cm skin tear to her right arm.</p> <p>The Documentation Procedure and Guidelines policy was provided by the Director of Nursing (DON) on 6/23/11 at 2:51 p.m. The purpose of the policy included, but was not limited to: "To reflect the quality of care provided to each resident. To document the resident's progress toward care plan</p>						

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	<p>goals, interventions, and response to treatment."</p> <p>The policy: "It is the policy of the Nursing Department to maintain the following schedule for documentation, unless otherwise indicated by the resident's condition: The nursing documentation standards included, but was not limited to, the following: "Skin Conditions: documentation of new skin tears, rashes, lesions, abrasions, etc. will include an initial assessment note-initial assessment must include accurate, detailed description and measurements, as appropriate; progress may then be documented on a weekly basis thereafter until resolved. This information may be documented in nurse's note and/or on specialized clinical form. However, if acute complications are noted such as signs of infection during treatment application or during skin assessment, the nurse will document the change in status, notify the physician and will then monitor every shift x (times) 72 hours and/or until the acute symptoms resolve. Bruising/ecchymosis: For new onset of bruising/ecchymosis, the nurse will complete an incident report and initiate investigation report to determine origin. Documentation will</p>						

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	<p>include assessment x (times) 72 hours to monitor for any complications. All areas documented must include measurements and color of bruise and/or ecchymosis."</p> <p>Interview with CNA #2 on 6/23/11 at 6:28 a.m., indicated there was no special care issues in regard to Resident #73. She then pulled her resident care sheet out of her pocket to indicate she was carrying her care sheet.</p> <p>Review of the CNA care sheet that was provided by CNA #1 on 6/23/11 at 10:32 a.m., indicated the resident was to have on geri-sleeves.</p> <p>On 6/23/11 at 1:30 p.m., CNA #1 was observed pulling back the covers on the resident. The resident had on short sleeves and a dressing was observed on her right forearm. CNA #1 reviewed her care sheet and indicated the resident was to have on geri-sleeves. She then indicated she could not find the geri-sleeves this morning and that was why she did not have the geri-sleeves on at this time.</p> <p>Interview with the Director of Nursing on 6/23/11 at 2:20 p.m., indicated skin tear documentation would be in the nursing notes and added to the</p>						

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	<p>Treatment Administration Record, however bruises were not. She further indicated the facility was in the process of changing the policy of skin tears and bruises. The facility will be adding the bruises to the Treatment Administration Record and they will be measured by the Wound Treatment Nurse. She then indicated this policy had not been implemented at this time.</p> <p>Interview with the Director of Nursing on 6/24/11 at 2:20 p.m., indicated no interventions had been put into place after the resident received a skin tear on 3/28/11 or the bruises were observed on 4/1/11 to prevent further bruising or skin tears. She further indicated the nurse who performed the skin check on 4/1/11 marked every little spot on the resident's skin. She was not sure if the resident had on her geri-sleeves or long sleeves when she received her skin tears during the transfer on 4/30/11. The Director of Nursing was aware the resident had not had on her geri-sleeve or long sleeves for the past two days and indicated the resident should have had on geri-sleeves or long sleeves.</p> <p>3.1-37(a)</p>						

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F0318 SS=D	<p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident with a limited range of motion received the treatment and services to prevent further contractures related to range of motion and splint application for 1 of 3 residents reviewed for contractures of the 7 residents who met the criteria for contractures. (Resident #13)</p> <p>Findings include:</p> <p>On 6/23/11 at 8:55 a.m., Resident #13 was observed up in a wheelchair in her room. There was no splint on her right hand. At 2:30 p.m., the resident was in her room with her eyes closed, sitting in a wheelchair. There was no splint on her right hand.</p> <p>Interview with the resident on 6/23/11 at 2:50 p.m., indicated the CNA had not put her splint on her hand all day as of that time.</p> <p>On 6/24/11 from 8:15-9:00 a.m., the resident was up in her wheelchair in the dining room. She was not wearing her right hand splint.</p>			F0318	<p>F -318 ROM 1) Resident #13 will have splint in place as ordered. 2) Any resident with a current order for splint/splints to be worn will have application as ordered. 3) Restorative Program will add splint application to their assignments 7 days per week. Documentation of application will be on the Restorative forms. 4) The Unit Manager or designee will check med orders/care plans and confirm for presence of splints 3 times per week on various shifts and days of the week. Results of the reviews will be reported to the QA committee on a monthly basis ongoing. 5) completion date: 7-27-2011.</p>		07/27/2011

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	<p>Interview at 9:00 a.m., with the resident, indicated the CNA had not placed it on her hand after she was done helping her with morning care.</p> <p>On 6/24/11 at 12:45 p.m., the resident was up in a wheelchair in the main dining room eating lunch. There was no splint in place to her right hand. The splint was observed in her room on the bed side table.</p> <p>On 6/24/11 at 1:40 p.m., the resident was observed in her room. There was no splint to her right hand. At that time, CNA #3 was asked to see her CNA assignment sheet. The care for Resident #13 indicated she was to wear a right hand splint at all times. The CNA then indicated the resident was up when she got there, and she did not put her splint on at all during the day. She further indicated she would have to ask the nurse if the resident was to have the splint on because she did not know for sure as she normally worked downstairs on another unit. LPN #4 indicated at that time, the resident was to have the splint on her right hand. The CNA then indicated she would put the splint on the resident's right hand. The CNA walked into the resident's room and put on clean gloves to both</p>						

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	<p>her hands, and applied the splint to the right hand with the resident's help. The CNA did not perform any passive range of motion to her right hand before applying the splint. Interview with the CNA at that time, indicated she was unaware the resident was to have passive range of motion to her hand.</p> <p>The record for Resident #13 was reviewed on 6/23/11 at 9:25 a.m. The resident had the diagnoses of right knee replacement, arthritis, and stroke.</p> <p>Review of Physician Orders dated 9/14/10, indicated right hand resting hand splint for positioning on always, except during sleep. Another Physician order dated 10/27/10 indicated, Restorative nursing to remove right hand splint and provide passive range of motion to right hand up to 10 reps using gentle movement then reapply splint.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated 5/27/11, indicated the resident was understood, and able to understand. The resident was alert and oriented to person, place and time. The resident needed limited assistance for all ADLs. The resident had upper</p>						

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	<p>extremity and lower extremity impairment to one side.</p> <p>Review of the current plan of care updated on 3/8/11, indicated the resident required assist with ADL care. The nursing approaches were to apply a right resting hand splint for positioning as ordered. Another plan of care updated 3/8/11, indicated the resident was at risk for contractures related to decreased range of motion. The nursing approaches were to provide Restorative nursing program for passive range of motion (PROM) to the right hand up to 10 reps, gentle movement, then reapply the splint and to apply a right hand resting splint.</p> <p>Review of the functional maintenance program sheets for the months of 5/11 and 6/11, indicated there was no documentation the splint application and range of motion was being completed for the day and evening shifts.</p> <p>Review of the joint mobility assessment dated 5/19/11, indicated the right wrist, right hand and fingers were severely impaired.</p> <p>Review of Nursing Progress notes for the month of June 2011, indicated</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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	<p>there was no documentation the resident refused range of motion or the application of the splint.</p> <p>Interview with the Restorative Nurse on 6/23/11 at 4:00 p.m., indicated the resident was not on the restorative program for the splint application and that it was up to the CNAs on the floor to put her splint on and do the range of motion.</p> <p>Further Interview with the Restorative Nurse on 6/24/11 1:53 p.m., indicated the CNAs were to perform range of motion and apply splints on those residents who wear the splint all day.</p> <p><b>3.1-42(a)(2)</b></p>						

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F0329 SS=D	<p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure monitoring was adequate, regarding blood work was not obtained as ordered for a resident who was receiving anti-coagulant therapy, for 1 of 10 residents whose drug regimens were reviewed in the sample of 41. (Resident #5)</p> <p>Findings include:</p> <p>The record for Resident #5 was reviewed on 6/23/11 at 11:05 a.m. The resident's diagnoses included, but were not limited to, pacemaker and cardiomyopathy.</p>		F0329	<p>F -329 Unnecessary Drugs 1) Resident # 5 PT/INR was drawn and reported to the physician. 2) All residents receiving Coumadin therapy have the potential to be affected. All PT/INRs are scheduled per policy. 3) Nurses will be in-serviced on Lab Policy and Procedure by 7-26-11. Unit Managers will monitor all PT/INR orders 5 days per week to assure they are accurate, complete, and completed timely. 4) Unit Managers will report findings of the PT/INR reviews to the QA committee monthly until compliance is achieved at 95% ongoing. 5) completion date: 7-27-2011.</p>		07/27/2011	

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	<p>A Physician's order dated 5/17/11, indicated the resident was to receive Coumadin (a blood thinner) 3 milligrams (mg) daily. A PT/INR (blood clotting studies) was to be obtained on 5/20/11.</p> <p>There was no PT/INR documented for 5/20/11 on the resident's PT/INR log.</p> <p>A Physician's order dated 6/16/11, indicated a PT/INR was to be obtained on 6/16 and then monthly.</p> <p>The resident's PT/INR was greater than 7.5 (elevated clotting time) on 6/16/11 and a Physician's order was obtained to hold the resident's Coumadin on 6/16/11 only and have lab draw a PT/INR on 6/17/11.</p> <p>The resident's lab results from 6/17/11 indicated the following: PT-120 (Critical) INR greater than 11 (Critical). The physician was notified and orders were received to hold the Coumadin until further notice and obtain a PT/INR on 6/20/11 and if any bleeding was noted, to send the resident to the hospital.</p> <p>The resident's plan of care dated 5/24/11, indicated the resident was at risk for hemorrhage due to routine</p>						

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	<p>use of anticoagulants. The plan of care was updated on 6/17/11 and indicated the resident's PT/INR was elevated and the resident refused to go to hospital. One of the approaches listed, indicated the resident's PT/INR was to be obtained as ordered.</p> <p>Interview with the Second floor Unit Manager on 6/23/11 at 1:55 p.m., indicated PT/INR's were to be collected by the way of a fingerstick unless specifically ordered for lab to draw.</p> <p>Interview with LPN #5 on 6/23/11 at 1:55 p.m., indicated that she was caring for the resident on 5/20/11 and she did not collect the PT/INR. She indicated the Unit Managers do the fingersticks. She also indicated that she didn't remember the resident having a PT/INR collected prior to 6/17/11 when it was elevated.</p> <p>Interview with the Second floor Unit Manager on 6/24/11 at 10:30 a.m., indicated the PT/INR on 5/20/11 was not obtained as ordered.</p> <p>Interview with the Director of Nursing on 6/27/11 at 10:00 a.m., indicated the nurses' working the floor do not obtain the fingersticks for PT/INR, the</p>						

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F0371 SS=F	<p>Unit Managers were to do the fingersticks.</p> <p>3.1-48(a)(3)</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation and interviews, the facility failed to ensure the kitchen and pantry areas were clean, related to greasy sides of the stove, oven and grill, and outdated food in the pantries for 1 of 1 kitchen and for 2 of 2 pantries. This had the potential to effect 84 residents who resided in the facility. (The main kitchen and the first and second floor pantries)</p> <p>Findings include:</p> <p>1. On 6/20/11 at 9:15 a.m., during the brief Kitchen Sanitation tour with the Dietary Food Manager, the following was observed:</p> <p>A. Both oven hoods were dirty and had greasy slats.</p> <p>B. The Vulcan oven was dirty with a large amount of grease on top and underneath it.</p>		F0371	<p>F – 371 Food Sanitation 1) 1A. Both oven hoods and slats have been cleaned. B. The Vulcan oven has been cleaned. C. The griddle, oven, and the grill have been cleaned. D. Food crumbs under dry food storage racks have been removed and area cleaned. 2A. Thermometer has been placed in freezer and all 17 containers have been discarded. B. The expired Med pass was discarded immediately. The Styrofoam cup, carton of apple juice and cup of prunes have all been discarded. The plastic bag of items was also discarded. 3A. Thermometer has been placed in the freezer, and the 3 magic cups and bag of items were all discarded. B. The expired Med Pass was discarded. The container of pudding and the packages of lunch meat were discarded. The yellow spillage was removed and the refrigerator has been cleaned. 2) All residents have the potential to be affected. A new cleaning schedule will be implemented by the Certified</p>		07/27/2011	

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	<p>C. The griddle, oven, and the grill were observed with a large amount of adhered grease, grime and dried food substances on all sides, front and back.</p> <p>D. There were a large amount of food crumbs under the dry food storage wire racks.</p> <p>Interview with the Dietary Food Manager at that time, indicated all of the above areas were in need of cleaning.</p> <p>2. The nourishment refrigerator on the first floor was observed on 6/27/11 at 9:53 a.m. The following was observed:</p> <p>A. There was no thermometer in the freezer but all items in the freezer were frozen solid. There were 17 containers (ice cream, magic cups, or</p>			<p>Dietary Manager. Areas to be cleaned daily, weekly, monthly and/or quarterly will be identified as such and documented as having been completed and/or what repairs or replacements may need to be addressed. Repairs or replacement requests will be made to the Towne Centre Executive Director. 3) A new cleaning schedule will be implemented. Certified Dietary Manger (CDM) or designee will check daily for outdated foods, and thermometers have been replaced. 4) CDM or designee will monitor cleaning schedule and refrigerators and freezers daily. Consulting RD will perform a monthly sanitation inspection with results provided to the QA Committee for further evaluation and to provide any recommendations. Towne Centre Executive Director or designee will monitor weekly and report results to the QA Committee until compliance is met at 95% for 3 months consecutively then quarterly. 5) completion date: 7-27-2011.</p>			

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	<p>diabetic cups) in the freezer with no dates or expiration dates on the containers.</p> <p>B. In the refrigerator there was an open container of Med Pass 2.0 with an expiration date of 6/22/11 at 8:30 a.m. A Styrofoam cup with multi colored cooked pasta covered loosely with plastic wrap with no date or name on the container. A carton of apple juice that was unopened with best if used by date of 9/8/10. A cup of prunes with no name, date, or expiration date. A plastic bag with two sandwiches, a sugar free cookie, and container of jello. There were no names on the food items and the date on the plastic bag was 6/25/11.</p> <p>Interview with the Staff Development Director at this time, indicated the freezer was used by dietary since there was no freezer in the kitchenettes. She was not sure when the frozen cups were put in the freezer. She did not know who the pasta belonged to and indicated the apple juice and the Med Pass 2.0 had expired. The Staff Development Director removed the plastic bag of food, the pasta, Med Pass 2.0 and the apple juice.</p> <p>3. The nourishment refrigerator on</p>						

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	<p>the second floor was observed on 6/27/11 at 10:10 a.m. The following was observed:</p> <p>A. There was no thermometer in the freezer but all items in the freezer were frozen solid. There were 3 containers (magic cups) in the freezer with no dates or expiration dates on the containers. There was a bag with a resident's name and no date.</p> <p>B. In the refrigerator there were open Med Pass 2.0 containers with the following expiration dates 6/26/11 at 4:00 p.m., 6/26/11 at 9:00 a.m., and two boxes dated 6/22/11 with no time. There was an open container of chocolate pudding with no open date, or name on the container. There was a package of lunch meat with the resident's name but no date. The date on the lunch meat package was 6/25/11. There was a light yellow spillage on the bottle shelf of the refrigerator.</p> <p>Interview with the second floor Unit Manger at this time, indicated the bag in the freezer was brought by the resident's family and the family brings items in weekly. She did not see an expiration date on the frozen cups in the freezer. She did not know why all of the expired Med Pass 2.0 was in</p>						

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	<p>the refrigerator. She indicated there was spillage on the bottom self of the refrigerator. She further indicated there was no date on the lunch meat to know when the item was placed in the refrigerator.</p> <p>Interview with the Dietary Manager on 6/27/11 at 10:25 a.m., indicated there should be thermometers in all of the freezers. She further indicated she would get thermometers in the freezers on the first and second floor nourishment refrigerators. She indicated staff only put the cups in the freezer that they need for the meals. She did not know why there would be 17 cups in the freezer unless an entire box had been placed in the first floor nourishment freezer.</p> <p>3.1-21(i)(3)</p>						

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F0431 SS=F	<p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review and interview, the facility failed to ensure vials of insulin and nitroglycerin tablets were dated when opened for 2 residents in a sample of 41 and for 4 of 6 vials of Aplisol observed in 2 of 2 medication rooms. The facility also failed to ensure</p>			F0431	<p>F -431 Labeling Drugs 1) Resident #53 medications were destroyed. Resident #90 has been discharged to home the medications have been destroyed. Resident #30 Medications were destroyed, orders dc'd. Resident #22 A new label was requested from pharmacy and order change</p>		07/27/2011

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	<p>cautionary labels were in place for medication administration direction changes for 2 residents in a sample of 41. The facility also failed to ensure all medications were not expired for 1 resident in a sample of 41. This deficient practice had the potential to affect 88 of 88 residents who resided in the facility. (Residents #22, #30, #53, #90 and #108 First &amp; Second Floor Medication Rooms)</p> <p>Findings include:</p> <p>1. The first floor medication room was observed on 6/24/11 at 10:03 a.m. In the medication refrigerator was a vial of Humalog insulin for Resident #53. The vial was opened and there was no date indicating when the bottle was opened.</p> <p>Interview with LPN #2 on 6/24/11 at 10:03 a.m., indicated the bottle did not have a date when it was opened. She indicated the vial should have been dated when the insulin was opened.</p> <p>2. The first floor medication room was observed on 6/24/11 at 10:03 a.m. In the medication refrigerator was a bottle of nitroglycerin 0.4 milligrams (mg) tablets (a cardiac medication) for Resident #90. There was a "date</p>			<p>sticker added to current box. Resident #108 order change label was added to box and new label requested. Opened Aplisol was destroyed. 2) All residents have the potential to be affected. Nurses will be in-serviced on checking medication expiration dates and using label change and open date Labels by 7-26-11. 3) The Pharmacy tech will check for outdated medications monthly. Nurses will apply change stickers with each change in medication order that is appropriate. Unit Managers will review new orders for label changes to medications 5 days per week. 4) Director of Nursing or designee will review Unit Manger review reports two times weekly and report summary of the results to the monthly QA committee until 95% compliance is achieved for 3 consecutive months then quarterly. 5) completion date: 7-27-2011.</p>			

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	<p>opened" label on the bottle of nitroglycerin. There was no date listed on the label of the nitroglycerin to indicate when the medication was opened.</p> <p>Interview with LPN #2 at that time, indicated there was no date on the label. She also indicated the bottle should be dated when opened.</p> <p>3. The first floor medication room was observed on 6/24/11 at 10:03 a.m. In the medication refrigerator 3 vials of Tuberculin, Purified Protein Derivative, diluted Aplisol were observed. 2 of the vials were opened and there were no labels to indicate when they were opened.</p> <p>Interview with the First Floor Unit Manager 6/24/11 at 10:20 a.m., indicated there were no labels indicating the dates on which the vials were opened. She indicated the vials were to be dated when opened.</p> <p>Interview with the Staff Development Coordinator on 6/24/11 at 10:55 a.m., indicated all the residents on the first floor had the potential to be affected by the deficient practice.</p> <p>4. The first floor medication room was observed on 6/24/11 at 10:03 a.m. In</p>						

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	<p>the medication refrigerator, 10 Phenergan 12.5 mg suppositories were observed for Resident #30. 2 of the Phenergan suppositories had the expiration date of 02/2010. 8 suppositories had an expiration date of 02/2011.</p> <p>Interview with the First Floor Unit Manager on 6/24/11 at 10:20 a.m., indicated the medications were expired. She stated the medications should have been destroyed when they expired.</p> <p>5. The second floor medication room was observed on 6/24/11 at 10:55 a.m. There were 3 vials of Tuberculin, Purified Protein Derivative, diluted Aplisol in the refrigerator. 2 of the vials were opened and there were no labels indicating the dates the vials were opened.</p> <p>Interview with the Staff Development Coordinator on 6/24/11 at 10:55 a.m., indicated the vials were not dated when opened. She indicated the vials were to be dated at the time they were opened. She indicated the deficient practice had the potential to affect all the residents on the unit.</p> <p>6. On 6/23/11 at 10:06 a.m.,</p>						

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	<p>medication administration was observed for Resident #22. The resident received lisinopril (a medication to lower blood pressure). Review of the medication box at the time, indicated the administration order was for lisinopril 20 mg (milligrams) give one tablet daily. There was no label on the box to indicate a change in direction for the administration of the medication.</p> <p>The record for Resident #22 was reviewed on 6/24/11 at 9:05 a.m. The resident had diagnoses that included, but were not limited to, hypertension and diabetes. There was a physician's order dated 5/25/11, that indicated to increase lisinopril to 40 mg daily and discontinue lisinopril 20 mg daily.</p> <p>Interview with LPN #1 on 6/24/11 at 9:15 a.m., indicated that when a medication order was changed, staff was to apply a label that stated "direction change refer to chart" on the box. She indicated there was no direction change label on the box of lisinopril for Resident #22. She indicated a label stating there was a direction change should have been applied to the box of lisinopril when the physician changed the order on 5/25/11.</p>						

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F0465 SS=F	<p>7. Medication administration for Resident # 108 was observed on 6/24/11 at 8:43 a.m. Enulose liquid (a medication for constipation) was administered to the resident. The label on the bottle indicated, "give 15 ml (milliliters) orally every other day."</p> <p>The record for Resident #108 was reviewed on 6/24/11 at 9:40 a.m. There was a physician order dated 5/11/11 that indicated, "Enulose give 15 ml orally 2 days per week on Monday and Friday."</p> <p>Interview with LPN #2 on 6/24/11 at 9:49 a.m., indicated there was no "direction change refer to chart" label on the bottle. She indicated the physician had changed the order on 5/11/11. She also indicated there should have been a direction change label applied to the bottle of Enulose at the time the physician ordered the change in directions.</p> <p>3.1-25(l)</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interviews, the facility failed to ensure the kitchen</p>			F0465	F – 465 1) 1A) The ceiling tile frames have been painted. B)		07/27/2011

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	<p>was clean related to dirty walls, dirty PVC pipes, stained and rusty ceiling tiles, and dirty sprinkler heads for 1 of 1 kitchen areas. This had the potential to affect 84 residents residing in the facility. (The main Kitchen)</p> <p>Findings include:</p> <p>1. During the Brief Kitchen Sanitation Tour on 6/20/11 at 9:15 a.m., the following was observed:</p> <p>A. The ceiling tile frames were rusty throughout the kitchen including the dish room area.</p> <p>B. The white PVC pipes under the dish machine were dirty and greasy with dried food substance. The wall behind the dish machine was dirty with dried food substance on it.</p> <p>C. The white PVC pipes under the three compartment sink were dirty.</p> <p>D. The walls behind and under the food prep area and sink were discolored and in need of painting. The white caulking was cracked and discolored with a black and yellow substance.</p> <p>Interview with the Dietary Food</p>				<p>The PVC pipes under the dish machine and the wall behind the dish machine has been cleaned. C) The PVC pipes under the 3-compartment sink have been cleaned. D) The walls behind and under the food prep area has been painted and the caulking has been replaced. 2A) The ceiling tiles have been replaced. B) The sprinkler heads have been cleaned or replaced if unable to clean. C) The cabinets were locked immediately. D) The cabinets were cleaned and the areas under the steam table and between the cabinets and the floor have been swept and cleaned. 2) All residents have the potential to be affected. All areas have been added to the New cleaning schedule which includes chemical safety checks. 3) A new cleaning schedule and chemical safety checks will be implemented by the CDM. CDM or designee will monitor daily to assure the schedule is being followed daily. 4) CDM or designee will monitor cleaning schedule daily. Consulting RD will perform monthly sanitation and chemical safety inspections monthly which will be presented to the monthly QA Committee for review and to make any recommendations. Towne Centre Executive Director will monitor weekly and report the results to the QA committee until compliance is met at least 95% for 3 consecutive months then</p>		

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	<p>Manager at that time, indicated all of the above areas were in need of cleaning.</p> <p>2. On 6/24/11 at 9:20 a.m., the following was observed during the full Kitchen Sanitation tour:</p> <p>A. Twenty ceiling tiles were rusty and were water stained. All of the ceiling tiles were yellow discolored.</p> <p>B. Ten water sprinkler heads were rusty and dirty with dust.</p> <p>C. In the serving area on the first floor there were bottles of quaternary solution observed in an unlocked cabinet under the sink. The doors to the serving area were opened and unlocked.</p> <p>D. In the serving area on the second floor, the cabinets were observed with a white splattered substance on four of them. There was also a large amount of food crumbs, dirt and a bowl noted under the steam table. There were jelly packets and butter packets observed in a corner between the cabinets and the floor.</p> <p>Interview with the Dietary Food Manager at that time, indicated all of the above areas were in need of</p>				<p>quarterly. 5) completion date: 7-27-2011.</p>		

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F0514 SS=D	<p>cleaning.</p> <p>3.1-19(f)</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to inaccurate documentation on a fall risk assessment for 1 of 4 residents who were reviewed for falls in the sample of 41. (Resident #139)</p> <p>Findings include:</p> <p>The Record for Resident #139 was reviewed on 6/23/11 at 9:30 a.m. The resident was admitted to the facility on 6/17/11. The resident's diagnoses included, but were not limited to, status post right hip fracture and hypertension (high blood pressure).</p> <p>The Fall risk assessment dated</p>			F0514	<p>F -514 1) #139 has been re-assessed for Fall Risk. 2) All residents that have been identified as a fall risk have the potential to be affected. Nurses will be in-serviced on how to collect the data in order to complete the Fall Risk Assessments accurately. 3) This In-service will be completed by 7-26-11. Unit Managers will review all of the New Admissions and Re-admission Fall Risk Assessments by the following morning Nurses Meeting M-F to assure accuracy and present results to the DON/SDC for further training and/or other necessary interventions. 4) The Unit Manager will report results to the monthly QA Committee ongoing. 5) completion date: 7-27-2011.</p>		07/27/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155307		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2011	
NAME OF PROVIDER OR SUPPLIER  TOWNE CENTRE HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE 7250 ARTHUR BOULEVARD MERRILLVILLE, IN46410			
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	<p>6/17/11, indicated the resident scored a "7", a score of "10" or above indicated high risk. The "medications" section of the assessment indicated the resident scored a 2. This indicated the resident had received 1-2 antihypertensives and narcotics currently and/or within the last 7 days. Review of the resident's admission orders indicated the resident was receiving Atenolol (a blood pressure medication) 50 milligrams (mg) by mouth daily and Lisinopril (a blood pressure medication) 10 mg by mouth daily. The resident was also receiving Norco (a narcotic pain pill) 7.5/325 mg one tablet twice a day.</p> <p>Interview with the First floor Unit Manager on 6/24/11 at 11:10 a.m., indicated the medication section of the resident's fall risk assessment had been coded inaccurately on admission and the resident should have scored a "4" rather than a "2" indicating that he had received 3-4 of the medications currently and/or within the last 7 days.</p> <p>The "predisposing diseases" section of the assessment was coded as "0", indicating the resident had no conditions such as vertigo, hypotension, stroke, Parkinson's disease, loss of limb(s), seizures,</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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	arthritis, osteoporosis, and fractures.  Interview with the First floor Unit Manager on 6/24/11 at 11:10 a.m., indicated the assessment had been coded incorrectly and the resident should have scored a "2" indicating the history of fracture.  3.1-50(a)(1) 3.1-50(a)(2)						